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United States Military Health Care Operations in Multinational Missions

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UNITED STATES MILITARY HEALTH CARE OPERATIONS IN MULTINATIONAL MISSIONS

(ABSTRACT)

COL EVERETT W. NEWCOMB, III

For over 200 years, the United States military medical system has provided needed health care to the sick and injured soldiers, sailors and airmen of this nation on battlefields around the world. While the United States has taken part in alliances throughout its history, in more recent times it has become involved in multinational operations which have included both allied and coalition partners. The U.S. military health care system has been called upon to care for not only the U.S. participants but also in some cases for the non-American participants as well.

A new type of health care mission emerged, however, with the deployment of the 212th Mobile Army Surgical Hospital (MASH) to Zagreb, Croatia in October 1992 in support of the United Nations mission in the former Yugoslavia. Here the 212th MASH was virtually the entire U.S. contingent and provided health care support to over 25,000 personnel from 34 different nations. At the time of the deployment, there was very little doctrinal guidance to support health care operations of this type. Issues such as tailoring the hospital for the mission, unique demands required for participation in UN operations, the development and evaluation of host nation capabilities for assistance, medical evacuation requirements not found in U.S. operations, press relations and a host of other demands required unique, nondoctrinal solutions.

This paper evaluates those demands encountered in multinational military health care missions for which military doctrine offers little, if any, guidance and provides an assessment of possible courses of action. It then explores the future of multinational missions of this type and evaluates the costs, benefits and limitations of U.S. participation. For despite rapidly emerging doctrine, multinational medical missions will continue to present major challenges to planners and commanders alike.

DISCLAIMER

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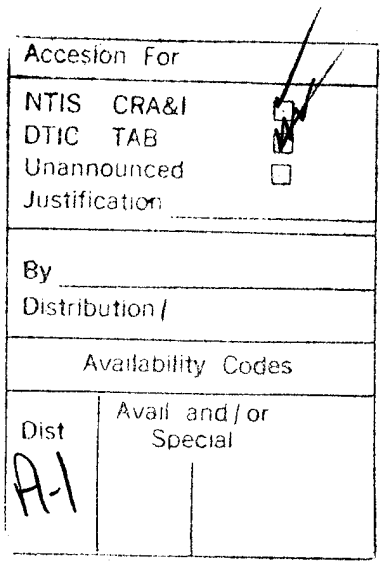

TABLE OF CONTENTS

INTRODUCTION: The United States military has long enjoyed overwhelming success in its varied operations around the world. One of the hallmarks of that success has been an adaptability to situations for which there have been no doctrinal solutions. Among the greatest achievements in this century has been an advancement in our ability to conduct joint warfare operations and to coordinate those operations with allied armies from one or more other nations. This has evolved to the more recent concept of coalition warfare with inherent multinational staffs and command structures. Unlike more formal alliances, coalitions "occur because an outside requirement overrides the inherent difficulties of creating and sustaining the coalition itself."[1] Doctrine for operations within multinational coalitions has just recently appeared in its infancy in U.S. joint military doctrinal publications.[4-6]

Operations which occur under the banner of the United Nations are the quintessential coalition missions. Headquarters staffs are truly multinational, with each staff functional area often assigned to a different country. Thus the G-1 functions might be assigned to Argentina, the G-4 functions to France, the medical oversight to a third country and so on. These staffs operate within the framework of United Nations regulations and standard operating proceedures (SOP's), but will frequently fall back on national doctrine when ambiguous situations arise.

The United States has participated in several multinational conflicts and operations during this century but through the Persian Gulf War at least has enjoyed the Command position and has been able to operate utilizing its own doctrine, whether fighting with alliance or coalition partners. Recently, however, the U.S. has participated in two large United Nations humanitarian missions. In Somalia, the U.S. was once again in the lead and was able to establish and conduct a doctrinal U.S. mission prior to turning the operation over to the United Nations. However, the United States embarked on an entirely new type of mission with the deployment of the 212th Mobile Army Surgical Hospital (MASH) to Zagreb, Croatia on 10 November 1992 as part of Operation Provide Promise. With the possible exception of a very brief period during our early involvement in Europe in World War I, this was the first time that United States forces of any kind were assigned to a non-American command, in this case the United Nations, operationally controlled by foreign commanders. This was subsequently repeated with the assignment of a United States infantry company to the United Nations in Macedonia in Operation Able Sentry.

The planning and execution of the medical missions in the former Republic of Yugoslavia (FRY) and to a lesser extent Somalia were highly nondoctrinal from the perspective of mission requirements for the

medical treatment facility and the personnel involved. This paper will attempt to examine the unique, nondoctrinal nature of these missions, drawing examples primarily from the mission to the FRY but to a lesser extent from other missions as well, It will identify specific difficulties encountered during these missions and the lessons learned from overcoming those difficulties, and finally explore the question as to whether the United States should continue to participate in missions of this type.

PREDEPLOYMENT CONSIDERATIONS

MISSION ANALYSIS: Common sense dictates that any operation starts with a thorough analysis of the mission statement. The end of the Cold War has made this all the more critical, however, especially from the medical perspective. Military medical treatment facilities in the inventory today were configured, staffed and equipped in the 1970's and 80's in order to meet the medical demands of a conventional conflict, especially in central Europe. With great foresight, the hardware was designed in a modular configuration which allows some flexibility in design and layout. Medical missions which have occurred since 1992 have been, to varying degrees, "nondoctrinal" in their requirements for

equipment and staffing. A brief analysis of the mission statement for the deployment of the 212th MASH will serve as a case in point.

> The 212th Mobile Army Surgical Hospital deploys a 60 bed hospital and support elements to Zagreb, Croatia to provide medical/surgical care with a holding capability of up to 30 days in support of United Nations Protection Force personnel in the former Yugoslavia.[2]

At the time that this mission was promulgated, medical planners had two options. The United Nations, through the U.S. Department of State, had requested a 60 bed facility with a theater evacuation policy of 30 days. In order to meet these requirements, medical planners could either send a slice of a 296 bed Combat Support Hospital (CSH) or send a 60 bed MASH facility. The obvious choice would seem to be the MASH, however a MASH is only staffed and equipped to provide the most basic care for patients with diseases or, more particularly, acute traumatic injuries. Its surgical capabilities are limited to acute resuscitative and lifesaving surgeries with an anticipated holding capability of 72 hours or less prior to evacuation to the rear for more definitive care. In order to be able to provide care to meet a 30 day evacuation policy, not only would acute resuscitative and stabilization care be required, but also an ability to provide definitive surgical, medical and to a limited extent, rehabilitative care. With the MASH (and to a lesser extent the CSH) this

would require a significant augmentation in terms of medical specialty care, nursing and support personnel, and surgical capabilities and equipment. In terms of this mission to the FRY, the 212th MASH was chosen over a CSH due to readiness considerations in favor of the MASH and the anticipation that sending the MASH, which already had much of its enlisted and some of its officer compliment assigned full time to its roster, would have less of an impact on residual peacetime healthcare in the remaining communities in Germany.

TAILORING THE HOSPITAL FOR THE HEALTHCARE MISSION: Mission analysis will determine, to a gross extent at least, whether the medical facility planned for deployment will meet the requirements of the mission. Contingency missions, especially with coalition or United Nations forces, will rarely fit the configuration of currently available U.S. field medical treatment facilities. While these facilities are modular by design, this modularity extends predominately to the physical layout of the facility and to a much lesser extent to specific medical capabilities.

It will, therefore, be necessary to specifically mission tailor the facility to meet requirements in most cases. In addition to theater evacuation policy, other factors which need to be considered include the availability and most importantly reliability of medical evacuation and the

capabilities of host nation medical treatment facilities and their willingness to assist with subspecialty care as required. These issues, which will be dealt with in more detail later, are never the less important considerations at the stage of mission tailoring. Again, the example of the 212th MASH will serve as a case in point.

After a thorough analysis of the mission statement and an in-country, on site assessment, it was determined that the basic MASH would require significant augmentation. Host Nation medical facilities in downtown Zagreb, Croatia were first rate in terms of quality, Western trained medical staff and state of the art equipment. With the assurance of appropriate compensation, they were more than willing to provide subspecialty consultation and sophisticated laboratory and radiological support. Due to a severe shortage of funds engendered by the war, the major deficiencies in these facilities were equipment maintenance and money to purchase reagents for the laboratory equipment. However, problems of some magnitude existed in the area of medical evacuation back to the soldier's home country. With the exception of the Western European contingents, many countries refused to accept their soldiers back until their illness or injury was resolved. The ramifications of this problem were that the 30 day holding requirement could (and indeed proved to be) considerably extended.

Consequently, in was determined that the surgical and orthopedic capabilities needed to be expanded in order to allow the performance of the definitive, reparative procedure. While this was easy from the standpoint of personnel, it was difficult in terms of equipment. Since no off the shelf packages of equipment were available, such as intermediate or advanced orthopedic packages, items required had to be individually identified and purchased. With only three weeks from the time of the warning order on 22 Oct 92 until the operational date of 15 Nov 92, these requirements placed an incredible burden on the logistics and procurement divisions at 7th Medical Command in Germany, the parent Command for the medical aspects of the mission. This must be an important lesson learned for future operations of this kind; off the shelf, preconfigured basic, intermediate, and advanced surgical and orthopedic equipment sets must be available for immediate deployment. A physical therapy section and associated equipment had to be assembled in order to provide rehabilitation of orthopedic and other patients. Additional elements, not normally organic to a MASH hospital, which were organized on short notice for deployment included a preventive medicine section, a mental health section, dental services to include a comprehensive general dentist and an oral surgeon with their associated equipment, increased internal medicine support for the treatment of complicated illnesses, and finally family practice services in order to

provide not only general medical care but also gynecological and basic pediatric care (some contingents and the UN civilians at UN Headquarters in Zagreb deployed with their families). The laboratory and pharmacy had to be vastly expanded in order to meet the demands of the now much larger hospital. In addition, support services across the board, from dietary services, to biomedical maintenance, nonmedical maintenance and logistics needed significant enlargement. Thus what finally deployed was a MASH hospital in name only, with capabilities somewhere between a MASH and CSH and in some areas even beyond those of the much larger CSH. Tailoring this facility was an extremely demanding job over a very brief period of time but represents the requirements which will be needed for future missions of this type. As noted, off the shelf, preconfigured equipment packages would make this job far less onerous for future contingency missions.

Emerging technologies such as telemedicine, telepresence surgery and digital imaging systems may play a significant role in planning for future deployments. These systems and others like them which are currently being fielded or developed may reduce the need for specialists in the field and allow them to provide long distance consultation or even assist in the operating room from a remote site. This could significantly

reduce the number of personnel actually required to deploy thereby minimizing the impact on residual healthcare back home.

UNIQUE PREDEPLOYMENT CONSIDERATIONS: Multinational, and in particular United Nations deployments require several unique considerations which can add a significant burden to predeployment planning. In the case of the United Nations, every vehicle and piece of military equipment, up to and including rotary wing aircraft, must be painted white with UN markings prominently displayed. During the deployment of the 212th MASH, this entailed the painting of 73 -20 foot shipping containers and ISO-Shelters and 17 wheeled vehicles. There was literally not enough white paint in the military inventory in Germany to meet this requirement and therefore demanded an extraordinary effort in terms of money to procure the paint in Europe and manpower to paint the equipment and vehicles in the 2 weeks available. This effort pales in comparison, however, to the demands for desert camouflage paint during the ramp-up for the deployment for Desert Shield and Storm.

The United Nations has additional requirements for the uniforms of those soldiers assigned to its missions. Combat helmets must be a specific shade of blue and soft headgear must be either a blue ballcap or

beret with a UN identifying emblem attached. Each soldier must wear either a brassard with a UN patch attached or have the patch sewn onto the sleeve of the uniform in addition to a patch of his national flag. Demands such as these are certainly not unique to the United Nations and can be expected in virtually any multinational operation. They can add a considerable burden to deployment and mission planning at a time when available resources and time are at a particular premium.

PREDEPLOYMENT TRAINING OF MEDICAL PERSONNEL: It would be difficult if not impossible to overstate the critical importance of predeployment training for medical personnel. The surest possible formula for dissatisfaction and disquietude among the medical staff, with the most dire of potential consequences for patient care, occurs when the staff are first acquainted with their medical equipment on arrival at the deployment site. Physicians, nurses and technicians in the military today are trained on highly advanced and in many cases state of the art equipment. The equipment which they will encounter in a field hospital, while technologically sound for the most part, will, in all likelihood, be generations removed from that which they are used to working with at their home medical centers. The initial response of many if not most clinicians on first encountering field hospital sets is that they can't possibly perform their clinical mission using such

equipment. While some augmentation of equipment may indeed be needed based on mission analysis considerations as discussed above, with proper predeployment training, safe and comprehensive care can be provided utilizing the field hospital equipment sets as provided. This training must include not only familiarization training but ideally actual patient care using the equipment in a safe and controlled environment at home station.

Sound medical planning for a deployment will always include a thorough analysis of the diseases likely to be encountered in the geographic area in which the deployment will be conducted. The Armed Forces Medical Intelligence Center (AFMIC), World Health Organization (WHO), Center for Disease Control (CDC) and local Preventive Medicine personnel can be relied upon to provide comprehensive information in this regard. Multinational operations, however, have additional and equally important demands. During the deployment of the 212th MASH to the FRY, patients from over 34 different nations were treated in the hospital. These nations ranged from Nepal and Jordan in the East to Chile in the West and from Finland in the North to sub-equatorial Africa in the South and the patients brought their native diseases with them. These diseases ranged from unusual presentations of diseases seen in the United States such as tuberculosis presenting as scrofula and various

forms of malaria to diseases seldom seen in the U.S. such as dengue fever and schistosomiasis. In a multinational environment such as that present in the FRY or Somalia, the ability to diagnose these conditions which constitute no less than a global textbook of medicine, places an extraordinary burden not only on the physician, but also on the supporting services in the laboratory and pharmacy. Consequently, it is incumbent upon the medical planners to provide both the clinical staff and the support services with detailed information regarding the environment in which care will be provided as well as demographic data on the beneficiary population to be served. While this might seem to be a statement of the obvious, it was the most important clinical lesson learned during the deployment of the 212th MASH to the FRY in 1992.

ONSITE CONSIDERATIONS

HOST NATION ASSISTANCE: As alluded to earlier, a thorough assessment of host nation medical capabilities is essential in order to determine the level of assets which must be deployed. This must include not only a determination of capabilities, but also the willingness on the part of the host nation to make their services available should the need arise. Several organizations, to include AFMIC and the WHO, can provide information concerning the medical capabilities, to include

hospital based facilities, of any country in the world. Such data, however, should not preclude an on-site evaluation if at all possible. Ongoing conflict within a country or even across its borders can quickly and easily overwhelm even a world class medical capability. In addition, in an attempt to destroy basic community infrastructure as in the current war in the Balkans, hospitals have been specifically targeted and destroyed thereby increasing the burden on those which remain. The possibility of utilizing hospital and support facilities in neighboring countries should also be considered such as was done in Kenya during the conflict in Somalia where host nation facilities were inadequate to support any but the indigenous population.

An assessment of host nation medical support should not be limited to an evaluation of hospital bed space alone. It must also include a determination of laboratory, radiological and other support capabilities such as orthotic/prosthetic labs and rehabilitation services with particular attention to the level of technician training, the quality of the data and services provided and the availability of reagents for and maintenance on the equipment on hand. Nova Hospital in Zagreb, Croatia is a brand new (completed in 1989) state-of-the-art facility by any standard in the world. Yet despite a greater than 90% bed occupancy rate, one was struck on entering the laboratory by how little activity

there was. Further evaluation revealed that despite state-of-the-art equipment, there was inadequate cash on hand to order reagents or to pay for more than minimal maintenance. The same basic story was found in the computerized tomography (CT) and magnetic resonance imaging (MRI) suites. Because of their unfortunate but extensive experience with battle casualties and land mine victims, however, their prosthetic and rehabilitation services were as good as any to be found in the western world.

The final assessment needs to be of the physicians themselves. This would include not only their training and capabilities, but also of equal or even greater importance, their attitudes toward assisting in the care of the deployed multinational force. In most countries, the word of the attending physician in a hospital is law and nothing is done without his expressed approval. Furthermore, tradition breeds prejudice which is only exacerbated by wartime tensions. Care must be taken to ensure that the same standard of healthcare is applied by host nation providers to each and every member of the various contingents within the multinational force. This requires, at a minimum, an understanding of the historical background of the conflict at hand.

MEDICAL EVACUATION REQUIREMENTS: A thorough understanding of available host nation support, one's own capabilities and the theater evacuation policy will provide an early estimate of the medical evacuation requirements out of theater. Multinational operations, however, entail additional complications and considerations. When dealing with United States or even NATO forces alone, evacuation to an appropriate level of care in the rear occurs as a matter of course and is an integral part of medical doctrine. The United Nations, however, conducts multinational operations under different standards. Medical evacuation of a sick or injured soldier to his home country occurs only after close coordination and consultation between the UN Command and representatives of the soldier's country. With the assistance of the UN, the home country must arrange and pay for the medical evacuation. This can run into many thousands of dollars if the patient is non-ambulatory, and many tens of thousands if a special flight needs to be employed for that patient alone. In addition, many countries are of the opinion that if one of their soldiers becomes ill or injured in the service of the United Nations then it is the UN which is solely responsible for the healthcare of that soldier until he has either fully recovered or died. Given the difficulty in procuring forces for UN multinational missions, it is understandable that the UN is reluctant to enforce its stated evacuation policies.

By way of example, it is estimated that in the former Yugoslavia there have been over 1 million land mines placed throughout Bosnia-Herzegovina and Croatia. Consequently, the most common combat related traumatic injury seen in UN soldiers were amputations attributable to these devastating weapons. Several countries refused to repatriate their soldiers until their amputations had healed, they were fitted with prosthetic limbs and in at least one case, were able to walk to the plane under their own power. Again this may be understandable given the rural living conditions and tenuous medical care available to many of these soldiers from third world countries, however it will extend their hospital stays to well in excess of the UN 30 day evacuation policy -in one case to 97 days! Therefore medical facilities must plan for hospital stays in excess of the stated evacuation policy and the associated increase in the complexity of care which will be required.

COMMAND AND CONTROL RELATIONSHIPS: In those multinational operations in which the United States assumes the lead, little if any difference will be appreciated in the chain of command- at least by the US contingent. It is in non-US led missions, however, that a different, complex and at times difficult and challenging command relationship arises.

The quintessential example of the non-US led operation occurs with the United Nations missions. Here, the UN Secretary General, usually at the behest of the Security Council or General Assembly, will appoint a force commander from one of the member nations. He, in turn, will develop a multinational military and civilian staff usually with augmentation by host nation civilians. The military staff will serve in general staff functions much like those in the US and other western countries. Due to the lack of formalized military doctrine and thus standardized procedures within the UN, the responsibility for each staff element will often be given to a different country. Thus the G1 (personnel) functions might be given to one country, G3 (operations) functions to another and so on. Consequently, when there is no "UN way" to solve a problem (no UN standard operating proceedure which covers the situation at hand), that staff element will fall back on its own country's doctrinal response which can obviously vary considerable from one country to another. Such an arrangement can and does lead to confusion and long delays in meeting mission requirements. This variability is only magnified in non-UN *ad hoc* coalitions where the entire command structure and working relationships need to be negotiated in detail at the outset.

Within a UN command, each national contingent has its own commander who is responsible to the UN force commander. By the UN general

principles which govern the organization of armed forces in UN military operations, contingent commanders retain the sole responsibility for discipline and regulations in force in their own national armed forces and are entitled to communicate directly with the authorities of their own country on all matters.[3] According to newly emerging US doctrine, US forces will be placed under the operational control (OPCON) of the UN force commander subject to previously negotiated and carefully defined parameters.[4,5,6] Within these parameters, at a minimum, foreign UN commanders cannot change the mission or deploy US forces outside of the areas of responsibility agreed to by the National Command Authority, separate or unite forces, redirect logistics and supplies, administer discipline, promote individuals or modify the internal organization of US units. Thus a US commander is responsible for his unit and mission accomplishment through a dual chain of command to both the UN force commander (often through one or more intermediate commanders) and to the National Command Authority through the theater combatant CINC. This can and does place additional burdens and complexities on the commander who can feel "caught in the middle" and who must exercise not only military but diplomatic skills and judgment while carefully treading the line between occasional conflicting objectives.

There is one valuable tool which is often available to US but not other contingent commanders. Despite funding 25-30% of the entire United Nations budget, the US will often directly pay for the costs of US participation in UN multinational operations unlike most other nations of the world which are paid by the UN for their participation. This can provide a certain flexibility to US commanders when US and UN interests diverge. By way of illustration, during the deployment of the 212th MASH to the former Yugoslavia in 1993, a US civilian helicopter pilot, who was a UN contract employee, crashed while flying a UN helicopter mission over Croatia. Upon arrival at the MASH, he was found to be critically injured. Both the patient and his immediate superior wanted him to be treated at the US hospital, however the UN Command stated that since he was not a member of UNPROFOR but rather a contract employee, he was not eligible for care at the MASH and would have to be treated elsewhere, citing as their main concern medical liability. Since this was a 100% US funded operation and under Title 10 of the US Code civilians can receive emergency treatment at US military medical facilities, the US Commander had the flexibility to be able to continue to provide care for this patient over the protestations of the UN Command.

One final, and uniquely medical consideration in this area is the delineation of eligible beneficiaries for care. This issue needs to be decided, preferably in writing, early in the course of mission planning-ideally before actual deployment. The wheels of the United Nations bureaucracy turn exceedingly slowly, especially where legal issues are concerned. This is important not only for mission planning but also for the preparation of the healthcare providers themselves. In most UN peace operations, the supporting military healthcare providers will be restricted to providing healthcare to the members of the UN contingents alone. This is understandable given that the UN must, of necessity, guard its neutrality jealously in situations such as Somalia and the former Yugoslavia. Care for displaced persons and other unfortunate individuals caught up in the horrors of the conflict must be left to the nongovernmental relief workers whose job it is to provide care for sick and wounded civilians and those in the refugee camps. This can be a difficult concept for military healthcare providers to understand especially if they are not very busy. Their natural inclination is to want to provide care wherever care is needed. However in situations like the former Yugoslavia in particular, any hint of a preference on the part of UN peacekeepers for one side or the other can and does result in retaliation not only against the populace but also against the peacekeepers themselves.

LANGUAGE SUPPORT: Nowhere are language skills more important than during the conduct of multinational operations. While this may seem a patently obvious statement, translators are needed for far more than communicating from commander to commander, especially in the medical arena. Indeed in the conduct of UN led operations, the official language in all headquarters and command communications is English. In medical operations, however, the greatest concern is the ability to communicate with patients. While pantomime and flashcards will do in a pinch, nothing beats being able to ask a patient where it hurts and be able to understand the answer. In the ongoing UN operation in the former Yugoslavia, patients from over 30 different countries have been treated in the US hospital there and most patients, who are enlisted soldiers and noncommissioned officers, have little to no English language skills. A surprising wealth of language abilities will be found in the personnel deployed with the hospital itself and any gaps can often be filled by someone at the multinational headquarters. Indeed during the 212th MASH deployment to the former Yugoslavia, members of the hospital staff were available who spoke French, German, Spanish, Arabic, Japanese and Norwegian. The most critical addition to the hospital staff before deployment, however, was the person who spoke Serbo-Croatian and other Eastern European languages--the languages of the host nation. These skills are necessary not only for direct patient care, but also for

communicating with host nation providers for consultative services as available and for arranging for laboratory and radiological tests and obtaining the results. In addition, regardless of the state of the infrastructure of the host nation, some direct negotiation for contract services will in all likelihood be required throughout the duration of the deployment. Finally, public relations with the people and government of the host nation and related countries can only be enhanced by a native language speaking individual preferably wearing a United States military uniform.

FORCE PROTECTION: There is nothing nondoctrinal about the overriding requirement to protect the soldiers of the force. Indeed volumes of US military doctrine have been devoted to this subject alone. In multinational operations, however, the concept of exactly what constitutes adequate security can vary widely. The job of the US commander can be made even more difficult when living on a multinational compound where the security for that compound has been delegated to another nation. The leading role that the United States plays in the world places its soldiers at greater risk than others in a multinational force. The flag which each US soldier wears on his sleeve makes him an unfortunately lucrative propaganda target for anyone wishing to make a statement to the world press. Thus the security

requirements for the US contingent (even, or perhaps especially, a hospital), are greater than for other countries and the US commander must be prepared to establish his own security arrangements. In addition to more standard and doctrinally publicized security practices, US field hospitals can utilize their cargo containers (MILVANS) to form a security perimeter which not only provides an element of security but also serves to channel patients to the correct portals of entry for care.

LOGISTICS: Multinational military operations under the UN banner have a robust (albeit extremely slow and cumbersome) logistics system. This should meet the demands for most US requirements less Classes V (munitions), IX (end item repair parts for US unique vehicles and equipment), and VIII (medical supplies). In the case of Class VIII, resupply of hospital based equipment, supplies and pharmaceuticals must come from US sources. In rare instances, pharmaceuticals and other limited items such as x-ray supplies may be obtained by local purchase, however care must be taken to ensure that the quality of those items meet US standards.

Resupply from US sources will usually entail reliance on the Air Force for transportation from the supporting medical logistics battalion should one not be collocated in the theater. The Air Force is understandably

reluctant to fly resupply missions that fail to fill the aircraft, however a hospital is dependent on a virtual constant stream of small volume items. Put another way, it takes an incredible number of aspirin tablets and syringes to fill a C-130. Possible work around solutions to this dilemma include the liberal use of package delivery services such as UPS or FEDEX, local procurement where feasible, and utilization of VIP aircraft which are smaller and far less expensive to operate. During the US deployment to the FRY, US Army U-21 and C-12 aircraft were utilized to make biweekly resupply flights from Germany, reserving the use of Air Force aircraft for the transportation of larger volumes of supplies and bulky equipment.

PRESS RELATIONS: During a recent presentation to the 1995 Class of the Industrial College of the Armed Forces, the Chief of Staff of the US Army, Gen. Gordon R. Sullivan stated that in this era of operations other than war, soldiers and relatively junior officers must be prepared to personally operate in strategic, operational, tactical and diplomatic roles.[7] To this must be added an ability to deal effectively with the press.

In this age of CNN and instant telecommunications, the press follows (and in some cases such as Somalia precedes) US forces. The introduction of US forces of any type into a multinational military

operation is of immediate and guaranteed interest to the world press. They will interview not only the leaders but also the soldiers of an operation and it is often the conduct of those soldiers in front of the cameras and microphones which will make or break the reputation of that unit or mission and can even have national implications. Training in those skills necessary to effectively deal with a demanding and increasingly aggressive world press corps is of paramount importance for all levels of a deployment force prior to embarking on a new or expanding mission.

THE US MILITARY HEALTHCARE ROLE IN FUTURE MULTINATIONAL MISSIONS--SHOULD WE PLAY?

The United States military healthcare system must and will be ready to go whenever US forces deploy on any mission worldwide. That is, after all, their very *raison d'être.* The question arises, however, about the role that military healthcare can and should play as an individual instrument of national policy when examining the possibility of US participation in multinational operations. Whether the mission is peacekeeping, peacemaking, humanitarian or disaster relief, the US military healthcare system has much to offer as the American standard bearer in a multinational force. It can go a long way toward demonstrating American

resolve to minimize human suffering and assist in establishing the moral highground for the greater good. The utilization of these assets, however, is not without a significant cost in terms of both dollars and, perhaps even more importantly, in further limiting the already scarce access to healthcare for both active duty and other military beneficiaries around the world.

CAPABILITIES AND LIMITATIONS: One of the greatest field assets of the American military healthcare system lies not in the application of healthcare at all, but rather in the ability of the U.S. military in general to move massive quantities of materiel over long distances on short notice. This has been a traditional weakness of many international relief efforts in the past.[8] Once on site, military medical facilities are generally self sufficient, providing their own shelter, food, water, electricity and other basic requirements. In addition, they deploy with their own organic command, control and, most importantly, communication systems.[9] Given the modular configuration of deployable healthcare systems, they can, as discussed above, be task organized and tailored for specific roles and missions. They are furthermore designed to be able to quickly establish a base of operations and provide acute medical care to the sick and injured. Units can also be deployed with minimal equipment in order to provide on site training to host nation or other private or

nongovernmental organization personnel. There are, in addition, several deployable modules which are unique to American military field hospitals. Among these are preventive medicine assets which are invaluable in mass disasters or refugee situations and sophisticated mobile microbiology and infectious disease laboratories.

One additional benefit of deployment accrues to the US military healthcare system itself. Participation in these missions involving the deployment of a medical unit which then takes care of actual patients provides the best possible training available for their wartime role of caring for injured US soldiers in the field.

Deployable medical facilities are not without significant limitations, however. They are specifically equipped to provide acute care, especially to trauma victims whereas the requirements of humanitarian and refugee missions are weighted far more toward the basic human needs of nutrition, immunization and the care of acute and chronic medical conditions. In addition, military healthcare providers are poorly trained in the diagnosis and care of the types of diseases seen under these circumstances. While additional training could certainly be provided, it would have to come at the expense of training for the primary mission of care for injured U.S. soldiers or from time now spent caring for other

beneficiaries in fixed medical treatment facilities where access to care is already significantly constrained. Lastly, while deployable medical systems are mobile, they require a huge transportation effort to deliver them on site. A single 30 bed MASH hospital, for example, requires approximately 14 C-141 sorties for in country delivery and then a large truck fleet to move it on the ground. And once on site, 30 beds have little meaning in situations such as recently seen in Rwanda, however can have a significant impact when providing care for the caregivers in humanitarian or disaster relief operations or for a large multinational peacekeeping force itself.

Being ever mindful of the limitations, in the balance there will continue to be an important role which the US military healthcare system can play in multinational operations. These valuable assets , however, must be used most judiciously and with great care, weighing the national policy benefits of US participation against the cost to those who rely on these assets for their day to day medical care.

CONCLUSION

Despite rapidly emerging doctrine, multinational medical missions will continue to present major challenges to planners and commanders alike.

Innovation and a willingness to respond to unconventional situations with unique answers will be the hallmark of these operations. Emerging new technologies may enable smaller units to deploy, however for the foreseeable future at least, nothing will replace the physician, nurse and technician on site and at the bedside. This will be particularly true when dealing with patients from third world countries for whom medical evacuation is not an option.

Even though some in Congress are now expressing reservations, the role of the US military in future multinational operations seems almost inevitable and where US soldiers, sailors and airmen go, so will go their healthcare support. US military healthcare units, however, have been used as stand alone elements of American foreign policy in situations where it has not been deemed wise from a policy standpoint to send combat units. For this reason, we in the healthcare arena must be prepared to respond again on very short notice and to meet the challenges of multinational deployments in the future.